

Prescription Drug Plan

Your Prescription Drug benefits are included as part of your Medical Plan coverage and are designed to help you manage the costs of drugs prescribed by your health care provider for you and your family.

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Highlights

Your Prescription Drug Benefits ...

... Allow You the Flexibility to Use a Network Pharmacy or Any Pharmacy You Choose

Benefits are higher when you use a network pharmacy, but you can go to any pharmacy you choose and still receive prescription benefits.

- Call Express Scripts at 1-866-749-0097 for assistance with locating a network pharmacy. This number is listed on your Express Scripts identification (ID) card.
- No claim form is required when you use a network pharmacy. When you fill a prescription at an out-of-network pharmacy or file a direct claim, you may be subject to pay the out-of-network deductible and then your co-pay or coinsurance of the approved cost for up to a 30 day supply of most Prescription Drugs.

... Offer a Convenient Home Delivery Option

The home delivery option, designed for maintenance drugs, provides up to a 90 day supply of a drug. You will pay the required co-payment or coinsurance. New prescriptions can be ordered by mail. Complete an order form and mail it with your prescription.

Mail: Express Scripts Health Solutions of Fort Worth
PO Box 650322
Dallas, TX 75265-0322

Fax: Your doctor may fax your prescription to Express Scripts. Have your doctor call 1-888-327-9791 for information on how to fax to Express Scripts.

Internet Refills: www.Express-Scripts.com

Telephone Refills: 1-800-473-3455. Have your ID card and your refill bottle with the prescription information ready.

How the Prescription Drug Benefit Works

Prescription Drug Benefits

Prescription Drug benefits are managed by Express Scripts.

Your out-of-pocket costs are based on one of three tiers: generic, brand preferred and brand non-preferred.

There are minimum and maximum limits on the coinsurance, which help protect you from the high cost of some drugs. If the cost of the drug is less than the minimum amount, you will pay the actual cost of the drug.

The preferred drug formulary includes over 1,800 drugs that may cost less than the non-preferred drugs that are not included in the formulary.

For short-term prescriptions such as antibiotics, you may fill up to a 30-day supply at a retail pharmacy. For long-term or maintenance drugs, use the Express Scripts mail-order pharmacy to get up to a 90-day supply and typically pay less for your prescription.

Prior Authorization

Certain prescription drugs may require a prior authorization (PA) to receive the prescription or full quantity that your doctor prescribes. If your drug requires this step, your doctor may need to provide additional information to Express Scripts before the drug may be covered under your insurance plan. These programs ensure that members get the right drug in the right dosage at the right time. They also encourage appropriate drug use and drug selection, and support the plan's provision of coverage.

Express Scripts's criteria and rules are determined by an independent Pharmacy & Therapeutics (P&T) Committee composed of nationally recognized medical and clinical pharmacy experts.

Retail Refill Allowance

This program encourages members to use the mail order pharmacy for maintenance drugs. You may receive up to three fills of the same maintenance drug at retail before having to move to the mail order pharmacy. If you continue to purchase the maintenance prescription at retail, you will pay the total cost of the drug.

Member Pays the Difference

This program encourages members to select less expensive generic equivalents when available. If you choose to stay on the brand name drug, whether doctor or patient requested, you will pay for the difference between the gross costs of the brand name drug and the generic drug, in addition to the generic copayment/coinsurance. If there is a clinical reason why you cannot take the generic drug, there is an Express Scripts appeal process for approval to pay only the brand name coinsurance.

Preventive Care Drugs

Certain contraceptive items identified by the Plan as preventive care are covered in full and are not subject to deductible limits or coinsurance. See the Summary of Benefits for a summary of the co-payments, deductibles, coinsurance, and related limits under each plan.

Infertility Drug Coverage

Infertility drugs are not covered under the Prime Select health insurance plan.

Administrative Information

Information about the administration of your Prescription Drug benefits can be found in the chapter titled "Administrative Information."

What happens to your benefits when ...

For more information about what happens to your Prescription Drug benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" chapter.

Summary of Benefits

Prescription Drugs, Provided by Express Scripts

Covered Services	Consumer Choice with HSA In-Network	Prime Select In-Network	Consumer Choice with HSA Out-of-Network	Prime Select Out-of-Network
Retail Prescription Drugs (Up to a 30 day supply)	<p>Member pays 100% until meets overall plan deductible of \$1,500 individual/\$3,000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$10/maximum \$75) after deductible</p> <p>Preferred Brand: 20% (minimum \$25/maximum \$150) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$40/maximum \$250) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$5 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$20/maximum \$100)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$40/maximum \$200)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	50% after plan deductible is met	80% after \$200 pharmacy deductible
Mail Order—Home Delivery (Up to a 90 day supply)	<p>Member pays 100% until meets overall plan deductible of \$1,500 individual/\$3,000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$10/maximum \$75) after deductible</p> <p>Preferred Brand: 20% (minimum \$25/maximum \$150) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$40/maximum \$250) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$12 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$50/maximum \$200)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$100/maximum \$400)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	Not covered	Not covered

Summary of Benefits (cont.)

Examples of prescription drug costs		
CONSUMER CHOICE with HSA: Retail Brand Preferred Coinsurance Examples		
Drug Cost	20% Coinsurance	Member Pays
\$60	\$12	\$25 (minimum payment)
\$150	\$30	\$30 (20% of covered cost)
\$800	\$160	\$150 (maximum payment)
PRIME SELECT: Retail Brand Preferred Coinsurance Examples		
Drug Cost	30% Coinsurance	Member Pays
\$60	\$18	\$20 (minimum payment)
\$150	\$45	\$45 (30% of covered cost)
\$400	\$120	\$100 (maximum payment)

Other Important Information (cont.)

Prescription Drug Claims Review and Appeal Procedures

Claims and appeal for benefit coverage claims

Urgent Care Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of

the information. If you don't provide the needed information within the 48 hour period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call 800-753-2851.

In addition, you also may have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo, or Tagalog). If you are not

Other Important Information (cont.)

satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Other Prescription Drug Claims (Pre-Service and Post-Service)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45 day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45 day period, your claim is considered "deemed" denied, and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to

review your claim. If you are not satisfied with the decision on your claim (or if your claim is deemed denied), you have the right to appeal as described below.

Appeals Procedure

The plan has a two-step appeals procedure for coverage decisions. If you are not satisfied with the decision regarding your benefit coverage or if you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not submitted in a timely manner), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

Level-One Appeal

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or within 30 days of receipt of your written request for post-service claims.

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not submitted in a timely manner) if your situation is urgent. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to

Other Important Information (cont.)

regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim.

If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond before issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life, health, or ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or if you do not agree with the determination of the external review organization, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any, considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed

to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings, which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim.

Level-Two Appeal

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

**Express Scripts,
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030**

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any considered by the plan in relation to your appeal; the plan provisions on which the decision is based; and a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review

Other Important Information (cont.)

of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal.

You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond before issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to bring a civil action under ERISA Section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedure

The right to an independent external review is available only for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a

quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal before, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851
Fax: 1-888-235-8551

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business

Other Important Information (cont.)

days for consideration to the IRO. Any additional information you submit to the IRO also will be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision.

If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review, and you have the right to bring civil action under ERISA Section 502(a).

Urgent External Review

Once you have submitted your urgent external review request, your claim will be reviewed immediately to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be managed adequately without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will be reviewed immediately to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a).

Direct Reimbursement Claims and Appeals

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The claim will be processed based on your plan benefit.

To request reimbursement, send your claim to:

Express Scripts
PO Box 14711
Lexington, KY 40512

You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 30 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed and you will have until that date to submit the missing information. If you do not submit the information by the required date, your claim is deemed denied and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information, the claim's stale date cannot be determined, your claim will be denied and you have the right to appeal the decision as described below.

If your claim is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes, and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim.

If you are not satisfied with the decision on your claim or if your claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Other Important Information (cont.)

Appeals Procedure

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal, including missing information

This information should be mailed to:

Express Scripts

Attn: Appeals

PO Box 631850

Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; the plan provisions on which the decision is based; a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes; and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative

(such as your physician). To initiate a second level appeal, provide the following information in writing:

- your name
- member ID
- phone number
- the Prescription Drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts

Attn: Appeals

PO Box 631850

Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved; the specific reasons for the decision; new or additional evidence, if any considered by the plan in relation to your appeal; the plan provisions on which the decision is based; a description of applicable external review processes; and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file; the right to receive, upon request and at no charge, the information used to review your second level appeal; and the right to present evidence and testimony as part of your appeal.

You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered, or generated in connection with the determination of your claim). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

Other Important Information (cont.)

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under ERISA, you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedures

The right to an independent external review is available only for claims involving medical judgment or rescission. You can request an external review by an IRO as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination. (If the date that is 4 months from that date is a Saturday, Sunday, or holiday, the deadline is the next business day.) Your request should be mailed or faxed to:

Express Scripts

Attn: External Review Requests
PO Box 631850
Irving TX 75063-0030

Phone: 1-800-753-2851

Fax: 1-888-235-8551

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an IRO, and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will be assigned randomly to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review, and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan, and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA Section 502(a). If the IRO has determined your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA Section 502(a).

